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TWO INTERESTING CASES

EXTENSIVE PERITONITIS

PERFORATION OF THE RECTUM

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BOSTON, MASS.

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THESE two cases are believed to be worthy of report because every case of general peritonitis recovering is of interest to the surgeon, and is always open to more or less question, and the second case is interesting etiologically at least. The folds of peritoneum are many, and I confess that personally I always feel that cases of general peritonitis which recover are, in the vast majority of cases, open to doubt. Every surgeon has had a number of cases which he classes as general peritonitis in which recovery has taken place; but it seems to me that the entire question is one of what we call general peritonitis, and unless the case comes to the necropsy table I do not see how any surgeon can be absolutely certain that his case is one of actual general peritonitis. He knows that a great amount of peritoneal surface is involved; it certainly appears to him at operation a generalized condition, but the folds of peritoneum are many, and in the face of what appears a generalized process he is not prone to push into every recess of peritoneum to satisfy himself if it, too, is involved in the process.

The following case, I think, illustrates this and also illustrates what I believe to have been a great mistake in the treatment of these cases in the past,

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namely, the use of large quantities of salt solution to flush out the abdomen.

Case I.—A clerk, aged 48, who had never before suffered from symptoms referable to his appendix, was taken with pain in his abdomen and was seen twelve hours after the initial symptoms. The usual signs of peritonitis were present; a temperature of 103°, a rigid abdomen, constipation, etc. He was operated upon sixteen hours after the initial attack at the Elliot Hospital. The intestines were distended and covered with pus and exudate. The appendix was swollen to the size of half a fist and absolutely gangrenous. It was lightly adherent to the posterior abdominal wall, but nowhere else was there any attempt on the part of the peritoneum to wall it off by adhesions. The wound was enlarged upward and downward to give a free opening. Pus was present outside the ascending colon and under the liver, every coil of intestine which could be seen was bathed in the same purulent exudate, and the hand carried to the left side was followed on withdrawal by quantities of pus. So far as any one could see, it was a generalized process and was considered as such by both myself and my associate. The appendix was tied off and large gauze and rubber tissue wicks were used for drainage (no tubes being used), one in the pelvis, one to the posterior abdominal wall where the appendix had been held, one running upward outside the ascending colon, and one carried to the left between the coils of intestine where usually I never place a drain. The abdomen was not washed out, the worst of the intestinal coils which presented themselves were lightly wiped with gauze, and the wound was left wide open. The patient was placed in Fowler's position. Neither one of us expected him to recover, and his convalescence was a protracted one. The entire deep fascia as far as the

median line sloughed away. He developed a septic pneumonia, but recovered finally, and was discharged, and is to-day well, barring a very large abdominal hernia. It is unfortunate in this case that no culture was made, and therefore the offending organism is not known. As so many recoveries from general peritonitis, due to the pneumococus have been reported, and especially on account of the lung complication, it is possible that this case was due to this cause, but the especially interesting features of the case to me, and the only reason for reporting it, were the rapidity and virulence of the process and the treatment without another incision and without flushing out the abdomen, together with the drainage by rubber tissue wicks inside of tubes.

Was it a general peritonitis? This simply depends on what one calls a general peritonitis and whether such a condition can be diagnosticated absolutely outside the autopsy room.

Case II.—This presents what is, at least to me, a unique cause of traumatic perforation of the rectum. The patient, a young and fleshy woman, was taking a rectal enema of oil, using a hard rubber hand syringe with a two-inch nozzle, in the semi-sitting position. She lost her balance and fell, pushing the entire syringe with the exception of the ring handle, into her rectum. The pain was excessive, but the syringe was easily withdrawn and as the patient did not find blood, following its withdrawal, she became convinced that no injury had resulted. The pain in the lower abdomen continuing she took an enema of a quart of salt water, which was partly expelled. During the night, following the accident, the pain continued; she vomited, but being so much better the following morning, she went to her work (that of a bookkeeper), but was compelled to lie down some of the day.

Twenty-four hours after the accident I was called to see her. Her temperature was 102°, her pulse 100. Her abdomen was somewhat distended, tympanitic, but with little rigidity. The pain was better, but was still present, and on vaginal examination was pronounced on lifting the cervix. She was sent to the hospital. A rectal examination, without ether, disclosed a rent in the right anterolateral wall of the rectum (knee chest position) four to four and a half inches above the sphincter. On November 23, at the Elliot Hospital, twenty-six hours after the initial injury, I opened her abdomen, disclosing the internal tear low down in the pelvis, extending between the uterorectal folds. There was a little dark blood-stained exudation in the cul-de-sac and a local peritonitis. The operation was without special interest and without special difficulty, save for the distention of bowel, due to lack of preparation, and a very fat abdominal wall. The rent was sutured and the wound drained with a cigarette drain.

On December 11, while progressing satisfactorily, she suddenly sat up in bed with a sharp pain in her left chest, and became cyanotic and dyspneic. Her respirations were 45 per minute and the pulse ran up to 160 and was barely perceptible, while edema of the lower lobe of the left lung developed rapidly. A diagnosis of probable pulmonary embolus of small extent was made and her convalescence was a long and stormy one. The drainage wound closed satisfactorily on January 7, and she was discharged on January 26, 1909.

The case seems of sufficient interest to report, on account of the manner of the injury and from the fact that a large enema was taken immediately following, without a more serious peritoneal involvement twenty-six hours after the injury.

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